TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Anesthesia Alliance of Dallas

Respondent Name
Safety National Casualty Corp

MFDR Tracking Number
M4-16-1359-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has issued a payment for our service but not the correct allowable per the 2015 Texas Workers Compensation fee schedule."

Amount in Dispute: $42.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. Coventry is standing by the pricing."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 18, 2015	01810 QX, P1	$42.99	$42.99

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.230 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt request, submit a copy of the EOR or clear notation that a rec
   - BL – This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states, "Please see the EOBs. Coventry is standing by the pricing." 28 Texas Administrative Code §134.230 (c) states,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor). For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service yearly conversion factor).

   Review of the submitted medical claim finds the requestor indicate "QX' modifier in box 24(D). This modifier is defined as, "QX – CRNA service; with medical direction by a physician." The reported place of service is "22" or "Outpatient Hospital".

   Per CMS Medicare Claims Processing Manual, Chapter 12, Section 140.4.4 – *"Conversion Factors for Anesthesia Services of Qualified Nonphysician Anesthetist Furnished on or After January 1, 1992, "Conversion factors used to determine fee schedule payments for anesthesia services furnished by qualified nonphysician anesthetist on or after January 1, 1992, are determined based on a statutory methodology." Services furnished in 1998 and after – 50.0 percent.*

   The allowable for the service in dispute is calculated as follows:

Allowable Base	Time Units reported on CMS 1500 ÷ 15 minute increment	Total	DWC Conversion Factor	Allowable
Code 01810 = 3	110 ÷ 15 = 7.33	3 + 7.33= 10.33	10.33 x 70.54(2015 DWC Conversion Factor for professional component of surgery performed in a facility setting) = $728.68 ÷ 50% = $364.34	$364.34

2. The total allowable for the service in dispute is $364.34. The requestor previously paid $247.28. The requestor is seeking $42.99. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $42.99.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $42.99 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 24, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.